SECTION 3.

QUALITY ASSURANCE REVIEW INSTRUMENT

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

QUALITY ASSURANCE REVIEW INSTRUMENTS FOR THE DIRECT OBSERVATION OF PUBLIC HEALTH DENTAL PRACTICE

AND

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

ORAL HEALTH SERVICES SECTION

Revised
June 2004

QUALITY ASSURANCE INSTRUMENT FOR THE DIRECT OBSERVATION OF DENTAL PRACTICE STRUCTURE

Tennessee Department of Health
Bureau of Health Services
Oral Health Services Section

CRITERIA	Yes	No	N/A	COMMENTS
I.A. FACILITIES				
Privacy (A.1.)				
Clean, Neat, and in Good Repair (A.2.)				
Access to the Disabled (A.3.)				
I.B. STAFF				
One Assistant per Dentist (B.1.)				
Current Licenses (B.2.)				
Unrestricted DEA Number (B.3.)				
Continuing Education (B.4.)				
Tennessee Dental Practice Act (B.5.)				
Policies, Rules, and Regulations (B.6.)				
I.C. ACCESS TO CARE				
Emergencies (C.1.)				
Recall (C.2.)				
Follow-up (C.3.)				
Discrimination (C.4.)				
I.D. INFECTION CONTROL				
Bloodborne Pathogens Standard (D.1.)				
Exposure Control Plan (D.2.)				
Annual Training (D.3.)				
CDC Recommendations (D.4.)				
Dental Unit Waterlines (D.5.)				
Critical and Semi-critical Instruments (D.6.)				
Noncritical Instruments (D.7.)				
Biologic Monitoring (D.8.)				
Instrument Storage (D.9.)				

Disposables (D.10.)				
Waste Disposal (D.11.)				
Handwashing (D.12.)				
Personal Protective Equipment (D.13.)				
Work Practice Controls (D.14.)				

CRITERIA	Yes	No	N\A	COMMENTS
I.E. MEDICAL EMERGENCY PREPAREDNESS				
Current CPR (E.1.)				
Oxygen Tank (E.2.)				
Stethoscope/Sphygmomanometer (E.3.)				
Emergency Kit and Drugs (E.4.)				
Emergency Phone Numbers (E.5.)				
Emergency Protocol (E.6.)				
I.F. RADIATION SAFETY				
Inspection Current (F.1.)				
Lead Apron (F.2.)				
Film Positioners (F.3.)				
Scatter Protection (F.4.)				
I.G. MERCURY HYGIENE				
Premeasured Amalgam (G.1.)				
Agitator Covered (G.2.)				
Storage of Scrap Amalgam (G.3.)				
Hazard Communication Standard (H.1.)				
Hazard Communication Program (H.2.)				
MSDSs (H.3.)				
Supply Inventory/List of Chemicals (H.4.)				
Annual Training (H.5.)				

Dentist _____ **Date** _____

Clinic Site _____ **Reviewer** _____

I hereby certify that I have read and understand the Quality Assurance Review as it pertains to me and my public health dental clinic

_____

SIGNATURE AND ADDITIONAL COMMENTS:

DIRECT OBSERVATION OF DENTAL PRACTICE STRUCTURE

FINDINGS:

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RECOMMENDATIONS:

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GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

I. DENTAL PRACTICE STRUCTURE

A. FACILITIES

1. Patients have privacy for treatment and confidential conversations in the operatory area.
2. Facilities are clean, neat, and in good repair.
3. The disabled have access to the dental clinic and operatory area.

B. STAFF

1. There is a minimum of one FTE chairside assistant per FTE dentist.
2. Staff maintains current Tennessee licensure, registration, or certification.
3. Dentist has a current unrestricted DEA number.
4. Staff has completed continuing education requirements for the past calendar year.
5. Staff never violates the Tennessee Dental Practice Act and the Rules of the Tennessee Board of Dentistry, which govern the practice of dentists, dental hygienists, and dental assistants.
6. All personnel rules, regulations, and policies promulgated by the state, the Department of Health, and appropriate local authorities are followed.

C. ACCESS

1. Patients with dental emergencies are seen on the same day they call if at all possible.
2. A recall system is utilized. Intervals are based on the dental need of the individual patient.
3. There is follow-up on all canceled or broken appointments.
4. There is no discrimination by payment source with regard to timing of appointments and nature of services provided.

D. INFECTION CONTROL

1. Staff complies with the OSHA Bloodborne Pathogens Standard. (Evaluate by using the Bloodborne Pathogens Compliance Checklist.)
2. A written Exposure Control Plan (ECP) is on file and accessible to staff. The ECP is reviewed at least annually and updated as necessary.

3. Staff participates in bloodborne pathogens and infection control training at least annually.
4. Staff adhere to the infection control practices for dentistry recommended by CDC (MMWR Dec 19, 2003, Vol.52 No. RR-17) in the treatment of all patients.
5. Dental unit waterlines to all instruments (high-speed handpiece, air/water syringe, and ultrasonic scaler) are flushed for several minutes at the beginning of each clinic day and for a minimum of 20-30 seconds after use on each patient.
6. Critical and semicritical instruments - After thorough cleaning, all heat-stable instruments, including handpieces, are heat sterilized. All other instruments are sterilized in 2% glutaraldehyde for ten hours. The central office strongly recommends using disposables when possible.
7. Noncritical instruments - After thorough cleaning, all instruments and medical devices receive intermediate- or low-level disinfection.
8. Proper functioning of sterilization cycles is verified by weekly use of biological indicators. Findings are kept in a log.
9. Sterilized instruments are stored in sterilizing bags or on covered trays.
10. Disposable covers and disposable supplies are used whenever possible. Disposable items are never reused.
11. Disposal of waste (liquid, sharp, or contaminated) is in accordance with local, state, or federal requirements.
12. Hands are washed thoroughly before and after treatment of each patient.
13. Protective attire (gloves; masks; and eye, face, and clothing protection) is worn, when indicated, by the dental staff.
14. Rubber dams, high-volume evacuation, and proper patient positioning are utilized to reduce formation of aerosols, droplets, and spatter.

E. MEDICAL EMERGENCY PREPAREDNESS

1. All staff has current CPR certification.
2. An oxygen tank with an appropriate valve, tubing, and mask is available. Dental staff is familiar with its location and use.
3. A sphygmomanometer and a stethoscope are available in the dental clinic.
4. An emergency kit is readily available. All dental staff knows its location and how to use the contents. The expiration dates of the drugs are current.
5. Emergency phone numbers are prominently posted.
6. All staff reviews the emergency management protocol at least annually.

F. RADIATION SAFETY

1. X-ray machines are inspected at the required 4-year intervals. Deficiencies are corrected in a timely manner.
2. Lead aprons are used on all patients receiving radiographs.

3. Film positioners are used. Neither patient nor staff holds the film during exposure.
4. Staff is protected from scattered radiation during film exposure.

G. MERCURY HYGIENE

1. Premeasured, disposable amalgam capsules are used.
2. The agitator of the amalgamator functions under a protective cover.
3. Amalgam scrap is stored in tightly closed containers and recycled properly.

H. CHEMICAL HAZARDS

1. Staff complies with the OSHA Hazard Communication Standard. (Evaluate by using the Hazard Communication Compliance Checklist.)
2. A written Hazard Communication Program (HCP) is on file and accessible to staff. The HCP is reviewed at least annually and updated as necessary.
3. Material safety data sheets (MSDS) are on file for each hazardous chemical. Any missing MSDS has been requested in writing, and a copy of the request is on file.
4. The inventory of chemicals, materials, and supplies and the list of hazardous chemicals in the HCP accurately reflect all the hazardous chemicals and products that are present in the dental clinic.
5. Staff participates in hazard communication training at least annually.

QUALITY ASSURANCE INSTRUMENT FOR
DENTAL RECORD REVIEW

Tennessee Department of Health
Bureau of Health Services
Oral Health Services Section

R E C O R D N U M B E R

CRITERIA										
II.A. MEDICAL/DENTAL HISTORY										
Dental Exam and Operative Record (PH-0205) (A.1.)										
Standard Medical Record Format (A.2.)										
Patient Information (A.3.)										
Health Questionnaire (A.4.)										
Follow-up (A.5.)										
Conditions Flagged (A.6.)										
Signed and Dated (A.7.)										
History Updated (A.8.)										
Dental History (A.9.)										
II.B. PATIENT EXAMINATION										
Consent for Treatment (B.1.)										
Blood Pressure (B.2.) (B.3.)										
Oral Conditions (B.4.)										
Charting Completed (B.5.)										
II.C. RADIOGRAPHS										
Adequate Area for Observation (C.1.)										
No Distortion or Overlapping (C.2.)										
Diagnostic Quality (C.3.)										
Bitewings (C.4.)										
Mounted and Labeled (C.5.)										
Pre-op Radiograph (C.6.)										
Patient Rejection Documented (C.7.)										

R E C O R D N U M B E R

CRITERIA										
II.D. TREATMENT										
Appropriate (D.1.)										
Treatment Sequence (D.2.)										
Documentation of Informed Consent (D.3.)										
Alternate Treatment (D.4.)										
II.E. PROGRESS NOTES										
Legible, Dated, and Signed (E.1.)										
Chronological (E.2.)										
Date of Service (E.3.a.)										
Tooth Number (E.3.b.)										
Nature of the Service (E.3.c.)										
Anesthetic (E.3.d.)										
Materials (E.3.e.)										
Prescriptions (E.3.f.)										
Additional Comments (E.3.g.)										
Charting of Treatment (E.4.)										
Canceled/Broken Appointments (E.5.)										
Documentation of Referrals (E.6.)										
Recall Plan (E.7.)										
Corrections (E.8.)										

Y - Yes N - No N/A - Not Applicable I - Insufficient information to determine

Dentist _____ **Date** _____

Clinic Site _____ **Reviewer** _____

I hereby certify that the Quality Assurance Review has been reviewed with me and I understand

Signature _____Date_____

DENTAL RECORD REVIEW

FINDINGS:

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RECOMMENDATIONS:

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II. DENTAL RECORD REVIEW

A. PERFORMANCE AND DOCUMENTATION OF THE MEDICAL/DENTAL HISTORY

1. A *Dental Examination and Operative Record* (PH-0205) is completed for each patient seen in the dental clinic.
2. Dental records are placed in the patient's folder in accordance with the standard medical record format and departmental medical record policy.
3. Key patient identification information (address, phone number, emergency information, and source of payment) is located on PH-0205.
4. The health questionnaire (medical history) contains no unanswered questions.
5. Possible compromising conditions are followed-up and documented.
6. Medical conditions or medications requiring an alert are flagged. Any condition that may affect dental treatment is noted on the treatment page.
7. The medical history is signed and dated by the patient and the dentist.
8. The medical history is updated at each appointment, and any change is noted on the form.
9. A dental history is taken on every patient and includes 1) problems with or reactions to anesthesia, 2) specific or chief complaint(s), and 3) problems with previous treatment.

B. PERFORMANCE AND DOCUMENTATION OF THE PATIENT EXAMINATION

1. Written (signed) consent for treatment is obtained for all patients.
2. Blood pressure recordings are taken at the initial examination of adult patients with a history or a familial history of hypertension.
3. Blood pressure recordings are taken on all adult patients prior to all surgical, invasive, or stressful procedures.
4. Oral conditions including restorations, caries, periodontal status, oral hygiene status and any other pertinent observations are recorded for each patient undergoing comprehensive or preventive care.
5. Charting of the examination findings are completed in the appropriate tooth grids on PH-0205.

C. RADIOGRAPHS

1. Periapical radiographs include all of the crown, roots, and surrounding bone in the area of observation.
2. Images of the teeth on periapical radiographs are not distorted or overlapped (where anatomically possible).
3. Radiographs have proper density, contrast, and detail.
4. Bitewing radiographs split the contacts if possible.
5. Intraoral radiographs are mounted properly and labeled with the date and patient's name.
6. A periapical radiograph with diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation).
7. Patient rejection of radiographs recommended by the dentist is documented and signed.

D. TREATMENT

1. The treatment for each patient is based on the history, examination, and diagnosis.
2. The treatment follows a logical sequence. Normally, with minor variations, this is:

    a. Relief of pain and discomfort
    b. Elimination of infection and traumatic conditions
    c. Caries control (removal of soft, deep caries)
    d. Prophylaxis, preventive procedures, and oral hygiene instruction
    e. Endodontic therapy
    f. Periodontal therapy
    g. Necessary extractions
    h. Restoration of teeth
    i. Replacement of teeth
    j. Placement of the patient on an individualized recall schedule

3. PH-3432 (*Informed Consent for Oral & Maxillofacial Surgery*) is completed for all oral surgery procedures. New written informed consent is obtained at each visit when oral surgery is performed.
4. Parents (guardian) are notified when there is an alternate treatment to a nonreversible procedure (e.g., extraction). If the parent elects the nonreversible procedure, informed consent for that procedure must be obtained.

E. PROGRESS NOTES

1. All progress notes are legible, dated, and signed by the provider.
2. All progress notes are in chronological sequence.
3. Documentation of services (treatment) rendered contains the following at a minimum:

    a. Date of service
    b. Tooth number, if appropriate
    c. Description of the service
    d. Anesthetic used, if any - including quantity
    e. Materials used, if any
    f. Prescriptions or medications dispensed including name of drug, quantity, and dosage
    g. Additional comments on referrals, consultations, and instructions

4. Charting of treatment is completed in the appropriate tooth grids on PH-0205.
5. Progress notes include the dates of all canceled and/or broken appointments.
6. Copies of all referral slips, responses, prescriptions, and telephone notes are kept in the patient's chart.
7. A recall plan is included in the progress notes.
8. Errors should not be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. CID (Correction in Documentation) is written immediately above the mistake, along with initials and date (if different from date of original entry).

QUALITY ASSURANCE INSTRUMENT FOR THE DIRECT OBSERVATION OF PATIENT CARE

Tennessee Department of Health
Bureau of Health Services
Oral Health Services Section

PATIENT'S RECORD NUMBER

CRITERIA										
III.A. DIAGNOSIS										
Initial Exam (A.1.)										
Initial Radiographs (A.2.) (A.3.) (A.4.)										
Recall Radiographs (A.5.)										
Appropriate Diagnosis (A.6.)										
Use of Diagnostic Aids (A.7.)										
Periodontal Disease (A.8.)										
Appropriate Referrals (A.9.)										
Appropriate Treatment (A.10.)										
III.B. PREVENTION										
Appropriate Preventive Procedures (B.1.)										
Prophylaxis/Recall (B.2.)										
Fluoride/Sealants (B.3.)										
III.C. OPERATIVE DENTISTRY										
Rubber Dam (C.1.)										
Water Cooling Spray (C.2.)										
Proper Sedative Fillings (C.3.)										
Appropriate Bases (C.4.)										
Complete Removal of Defective Restorations (C.5.)										
Restorations Reproduce Sound Tooth Contours (C.6.)										
Class II Restorations Performed Correctly (C.7.)										
Stainless Steel Crowns (C.8.)										
III.D. REMOVABLE PROSTHODONTICS										
Partial Dentures – Clinically Acceptable (D.1.)										
Complete Dentures – Clinically Acceptable (D.2.)										

PATIENT'S RECORD NUMBER

CRITERIA										
III.E. ENDODONTICS										
Radiograph (E.1.)										
Rubber Dam (E.2.)										
Obturation of Canal (E.3.)										
Pulpotomies Performed (E.4.)										
III.F. PERIODONTICS										
Proper Diagnosis (F.1.)										
Home Care Instructions (F.2.)										
Treatment (F.3.)										
Referrals (F.4)										
Recall (F.5.)										
III.G. ORAL SURGERY										
Complete Tooth Removal (G.1.)										
Root Tip (G.2.)										
Pre-op Radiograph (G.3.)										
Written Informed Consent (G.4.)										
Post-op Instructions (G.5.)										
III.H. EMERGENCY TREATMENT										
Palliative Measures Taken (H.1.) (H.2.)										
Appropriate Diagnosis (H.3.)										
Efficacious Treatment (H.4.)										
Temporary or Sedative Filling (H.5.)										
Initial Endodontic Treatment (H.6.)										
Appropriate Medications (H.7.)										
Appropriate Referral (H.8.)										

Y - yes N - no N/A - not applicable

Dentist _____ **Date** _____

Clinic Site _____ **Reviewer** _____

ADDITIONAL COMMENTS:

Signature _____

DIRECT OBSERVATION OF PATIENT CARE

FINDINGS:

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RECOMMENDATIONS:

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GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

III. QUALITY OF PATIENT CARE SERVICES

A. DIAGNOSIS *

1. An oral and extraoral examination is conducted on all initial care patients.
2. Initial radiographs for an adult patient consist of individualized films including bitewings and selected periapicals. A full-mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or extensive dental treatment.
3. For children with primary teeth only, radiographs are taken if proximal surfaces of the primary teeth cannot be visualized or if there are specific problems.
4. For children with a transitional dentition, initial radiographs consist of appropriate periapical views, occlusal views, and bitewings.
5. Recall radiographs are taken at a frequency based on caries activity, caries risk, disease activity, or specific problems.
6. A proper diagnosis consists of the patient's state of oral health and the existence of any pathology or abnormal condition including the causes and type of the pathology or abnormal condition. The primary tools are the history and clinical examination.
7. The diagnosis includes the use of a variety of aids as necessary, such as, but not limited to radiographs, study casts periodontal probing, pulp tests, percussion, palpation, transillumination, and biopsy.
8. Patients with periodontal disease are informed of their periodontal condition(s), and appropriate referrals are made for consultation and treatment.
9. The patient is referred for medical and/or dental consultation, if necessary, to reach a definite diagnosis.
10. The treatment for each patient is appropriate and is based on the history, examination, diagnosis, and discussion with the patient and/or parent (guardian).

**** This section must be completed for all patients (except emergencies) treated by the dentist during the direct observation of patient care. Evaluating the accuracy of the diagnosis and appropriateness of treatment will require the evaluator to consult the patient's dental record. The treatment rendered to the patient by the dentist is also to be evaluated using the applicable criteria in one or more of the following sections.***

B. PREVENTION

1. Treatment includes appropriate preventive procedures for each patient undergoing comprehensive care.
2. Professional prophylaxis, which removes plaque, extrinsic stains, and calculus, is performed at regular intervals appropriate to the individual.
3. Caries prevention in children includes, when appropriate, systemic or topical fluoride, sealants, and oral hygiene instruction.

C. OPERATIVE DENTISTRY

1. A rubber dam is utilized whenever possible.
2. A water-cooling spray must be used with high-speed tooth reduction.
3. Sedative treatment fillings are used only when gross caries have been removed.
4. Bases are used in all deep cavity preparations.
5. Defective restorations or restorations with recurrent caries are completely removed and replaced.
6. All restorations reproduce sound tooth contours, restore or achieve interproximal contact, and have flush margins.
7. Mechanical matrices and gingival wedges are used in the restoration of all class II caries with an adjacent tooth.
8. Significant interproximal carious lesions on primary teeth are restored with stainless steel crowns.

D. REMOVABLE PROSTHODONTICS

1. Partial dentures

    a. Partials are designed so that they do not harm the remaining teeth with undue stresses and/or create food traps.
    b. Abutment teeth requiring restoration should be restored with a crown or onlay if areas supporting retention devises are involved.
    c. Tissue-bearing areas are covered to the physiological maximum within acceptable esthetic limits.
    d. All patients receive thorough instruction in oral hygiene procedures.

2. Complete dentures

    a. Patients are informed of the limitations of complete dentures.
    b. Baseline radiographs of edentulous areas are taken before denture construction.
    c. Dentures cover the maximum areas physiologically possible.
    d. Dentures maintain vertical dimension and physiologic occlusion.
    e. Dentures are esthetic and shaped to minimize phonetic problems.
    f. All patients receive thorough instruction in oral hygiene procedures.

E. ENDODONTICS

1. An accurate paralleling radiograph of the involved tooth (including apices) is taken prior to the start of endodontic therapy.
2. A rubber dam is used in all cases of endodontic therapy.
3. Gutta percha is used in the root canal filling and is densely packed and sealed to about one millimeter of the apex.
4. Pulpotomies are not performed on primary teeth with apical involvement, intraradicular involvement, or noticeable mobility.

F. PERIODONTICS

1. Periodontal treatment is preceded by examination, diagnosis, and treatment planning.
2. All patients are instructed in home care to attain plaque control and caries prevention.
3. Mild periodontal diseases are treated by scaling, root planing, and replacing or modifying defective restorations.
4. Patients with moderate or advanced periodontal disease are referred to appropriate specialists for consultation, treatment, and follow-up care.
5. Periodontal patients treated in the clinic are placed on regular recall at intervals specific to the each patient.

G. ORAL SURGERY

1. When teeth are extracted, all portions of the tooth are removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with further attempts at retrieval.
2. If it is necessary to leave a root tip, the patient is informed; treatment options including referral are discussed; and all pertinent information is documented in the patient's record.
3. A periapical radiograph with diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation).
4. Written informed consent using form PH-3432 is obtained prior to performing any oral surgery procedure.
5. After extractions all patients are given oral postoperative instructions in addition to written postoperative instructions.

H. EMERGENCY TREATMENT

1. No patient is sent home or referred without measures taken to relieve his/her distress.
2. Patients with acute conditions that negate the ability to achieve adequate local anesthesia receive palliative treatment.
3. A sufficient number of radiographs with diagnostic quality are made, and other diagnostic aids are utilized, as needed, to reach a definitive diagnosis.
4. The emergency condition is treated by the most efficacious method.
5. If the tooth can be restored, but time does not allow for a permanent restoration, a temporary or sedative filling is placed after removal of gross caries.
6. If root canal therapy or pulpotomy is indicated, initial endodontic treatment is performed to relieve pain.
7. Appropriate antibiotics and/or analgesics are dispensed or prescribed as necessary.
8. If the emergency is complex and is beyond the ability of the dentist, the dentist arranges referral to appropriate dental treatment source.